DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES BUDGET STATUS

A Report Prepared for the

Legislative Finance Committee

by

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INTRODUCTION

At the December 2001 Legislative Finance Committee (LFC) meeting, staff briefed committee members on proposed changes to bring Department of Public Health and Human Services (DPHHS) fiscal 2002 projected expenditures in line with appropriations. In addition, staff noted several other areas of concern and raised issues related to some of the proposed changes. This update summarizes the changes that have been implemented, reviews issues and the newest budget projections, discusses a "refinancing" option that could offset some current general fund expenditures with federal Title XIX (Medicaid) funds, and identifies issues and options that the LFC may wish to consider.

SUMMARY OF MAJOR ISSUES

The main purpose of this report is to update the LFC on the budget status of DPHHS. The major issues in this report are:

- An ongoing general fund deficit in fiscal 2002 of $3.3 million and a short fall of $6 to $7 million over the biennium despite implementation of cost reduction measures estimated to save $9.9 million general fund
- A projected short fall in state matching funds of at least $0.8 million in fiscal 2003 in the Child Support Enforcement Division (CSED) in addition to the $6 to $7 million
- Availability of $2.7 million general fund in the Developmental Disability (DD) Program that DPHHS plans to use to expand DD services and fund a provider rate increase
- Potential to reduce general fund administrative costs for child welfare field staff by identifying foster care children as a group eligible for Medicaid targeted case management services

DECEMBER 2001 BUDGET PROJECTIONS

When the LFC last met, DPHHS was projecting a $4.4 million general fund cost over run in fiscal 2002, principally in Medicaid primary care and mental health services. The total projected cost over run was offset by savings in nursing home Medicaid services. Legislative Fiscal Division (LFD) staff noted that a short fall in state matching funds for CSED, which resulted in a potential 60 percent annual budget reduction, was not included in the DPHHS budget status report.

DPHHS issued an updated budget status report in March 8 that shows a net general fund short fall of $3.3 million general fund in fiscal 2002 and a biennial projection on March 12 that shows a total net biennial short fall of $6 to $7 million general fund despite implementation of cost saving measures briefly reviewed at the December LFC meeting. Prior to implementation of any cost savings measures the total projected biennial general fund shortfall is about $16 to $17 million, not including CSED costs.

DPHHS is refining biennial cost estimates and may have updated numbers for the March 13 LFC meeting.

Table 1 shows a biennial summary of all budget changes made by the executive to the DPHHS budget – as well as changes made in response to the initial budget short fall. The amounts included in Table 1 were provided by DPHHS between December 2001 and March 2002. Including reallocations of TANF appropriations, the executive made changes of over $53 million total funds, including $9.9 million general fund. Of these changes, about $5.1 million total funds ($1.3 million general fund) are service limitations, and provider rate reductions are $4.9 million total funds including $1.4 million general fund. Appendix A shows a detailed list of budget changes by division and discusses some of the changes in greater detail.

The single most significant type of change - about 35 percent - is appropriation reallocations, primarily in TANF funding for FAIM IIR items. Appropriation reallocations shift appropriation authority among

programs or uses, but do not change the overall level of spending. The next most significant category is other changes, which includes increases in co-payments by Medicaid recipients and collections from third party payors for Medicaid services as well as reductions in department operating costs.

Transfers from savings in other programs account for about 18 percent of the total change. The most significant transfer, $2.4 million general fund, is from the Medicaid appropriation for nursing home and home based services due primarily to lower caseloads than projected.

Provider rate reductions account for about 9 percent of the change. DPHHS has provided documentation that rate reductions have generated about $1 million in savings, which is about $0.3 million general fund, since the reductions were implemented January 1, 2002.

MOST RECENT MEDICAID ESTIMATES

As noted previously, preliminary Medicaid estimates based on February data show that DPHHS may still be short $3.3 million general fund in fiscal 2002 with a total biennial short fall of $6 to $7 million, despite the cost containment measures already implemented.

DPHHS is considering options to reduce the newest projected short fall. One division of DPHHS – Addictive and Mental Disorders – met with service providers March 12 and discussed additional reductions. Preliminary ideas discussed include a 5 percent provider rate reduction and elimination of case management services for adults eligible for the state funded Mental Health Services Plan (MHSP). Providers proposed cost reductions for discussion, which may be available for LFC review at the March 13 meeting.

Other options being considered by DPHHS include: provider rate reductions in hospital, physician, and prescription drug services; withholding of fiscal 2003 provider rate increases in those services and mental health services; and Medicaid service and eligibility reductions.

If more actions are taken this year and short falls were still to occur, the executive would need to transfer appropriation authority from fiscal 2003 to cover the short fall. Statutes governing such transfers require the executive to submit a plan for review by the LFC to maintain expenditures within appropriation authority in fiscal 2003 and to curtail all non mandated expenditures to the greatest extent possible (section 17-7-301, MCA).

Reasons for Medicaid Cost Increases

There are two primary reasons for Medicaid cost increases above the level projected during the 2001 session: a higher number of eligible persons and increased utilization of services. The 2001 legislature granted the executive budget request for Medicaid services, except for a small reduction to the nursing home request. The legislature also included two increases in the Medicaid appropriation in response unforeseen circumstances during the session.

During the session, DPHHS staff became aware of court cases that would expand the number of persons eligible under the aged, blind or disabled category of Medicaid eligibility. The legislature appropriated funds to support an additional 500 persons based on the executive estimate. However, the expansion in this population has been about 900 persons. Although the increase in this category of eligibility is slight, these are some of the most expensive Medicaid cases. For instance, the annual cost of providing services to a blind or disabled Medicaid recipient was about $7,800 in fiscal 1999 or eight times the annual cost of serving a low-income child.

The number of persons eligible for Medicaid also has increased as the cash assistance caseloads have increased. Although the eligibility between cash assistance and Medicaid was "de-linked" by federal welfare reform legislation about five years ago, the children of most families and some of the parents on cash assistance would qualify for Medicaid.

Utilization of some services is exceeding the historic trends used in the executive Medicaid estimates during the 2001 session. For instance, utilization of inpatient hospital services is increasing at an annual rate of about 13 percent,[1] compared to nominal increases in the past several years.

OTHER FISCAL ISSUES

There are several other fiscal issues important to the DPHHS budget, which include:

- Funding CSED
- Legal issues regarding the use of general fund available due to refinancing of DD services
- Cash assistance caseload
- Potential general fund cost offset by using federal Medicaid funds to support field staff costs in the Child and Family Services Division
- Federal grant levels for the Children's Health Insurance Program (CHIP)
- Use of interest income appropriated from the constitutional tobacco trust fund in fiscal 2003
- Reorganization of the Operations and Technology Division

FUNDING CHILD SUPPORT ENFORCEMENT DIVISION

Funding CSED is a significant issue due to federal requirements for the state to operate a child support enforcement program. The potential penalties for failure to do so could result in the state's loss of the federal Temporary Assistance for Needy Families (TANF) block grant that supports welfare programs. The Personal Responsibility and Work Opportunity Act of 1996 (PRWORA)[2] obligates states to provide child support enforcement services for children receiving TANF, foster care and subsidized adoption, or Medicaid funded assistance or services, and any other child, if services are applied for with respect to the child.

The March budget status report based on February data does not project a deficit in the CSED in fiscal 2002. However, DPHHS estimates a deficit of $0.8 million state special revenue ($2.4 million total funds) will occur in fiscal 2003. DPHHS staff estimates that state special revenue used to draw federal matching funds will be less than necessary to support the program.

LFD staff questions whether $600,000 of the state special revenue ($1.8 million total funds) that DPHHS estimates it will receive for fiscal 2003 will actually be realized and whether estimated expenditures are understated by $300,000 state special revenue ($900,000 total funds). If DPHHS revenue estimates are not realized and the expenditures are understated, CSED may have a deficit of $1.7 million in state special revenue or $5.1 million total funds, which is over half of annual CSED appropriation. Additionally, these

[1] John Chappuis, Deputy Director, Department of Public Health and Human Services, electronic mail message, March 6, 2002.

[2] PRWORA section 301 provides that the state will provide services related to the establishment of paternity or the establishment, modification, or enforcement of child support obligations with respect to each child for whom: TANF assistance is provided; foster care benefits or services are provided under Title IVE; and medical assistance is provided under Title XIX (Medicaid) and any other child, if services are applied for with respect to that child. PRWORA section 409(a)(8) provides for TANF penalties if a state fails to comply with child support enforcement requirements and section 408(a)(2) provides for reduction or elimination of TANF assistance to families that fail to cooperate with child support enforcement.

estimates do not include a potential unfunded liability that exists due to a child support investigators classification appeal. Appendix B contains detailed explanation of the variance in revenue estimates.

Mitigation Plan

DPHHS implemented a plan to mitigate the CSED funding short fall. The plan:

- Uses general fund from reverted appropriations to repay federal fiscal 2000 and 2001 overpayments
- Reduces expenditures by $446,000 state special revenue ($1.4 million total funds)
- Estimates a potential short fall of about $800,000 state special revenue ($2.4 million total funds) in the second year of the biennium

LFD staff has two concerns: 1) non-inclusion of potential liabilities; and 2) the impact of expenditure reductions.

Potential Liability

Potential liability due to a classification appeal decided by the Montana Supreme Court on March 12 is not included in DPHHS estimates of 2003 biennial short falls. The classification appeal results in an upgrade of investigators from a grade 13 to a grade 14. Preliminary information prepared by DPPHS estimated its liability for back pay and interest to be $408,000 in state special revenue ($1.2 million total funds). LFD staff estimate that liability could be closer to $500,000 state special revenue.

Reduction in Expenditures

DPHHS has taken several steps to reduce expenditure of state special revenue by about $446,000 ($1.4 million total funds) during the biennium. Three items comprise 93 percent of the expenditure reductions.

- Termination of the contract with Maximus for the customer service unit is estimated to reduce expenditure of state special revenue by $220,718 ($668,843 total funds) for the biennium.
- Transfer of SEARCHS costs to the Operation and Technology Division is estimated to shift $100,000 of expenditures from state special revenue ($300,000 total funds) for the biennium.
- Reduction in staff from 183.75 FTE to 174.25 FTE is estimated to reduce state special revenue expenditure by $95,207 ($285,621 total funds) for the biennium.

Termination of the customer service unit contract means that calls previously fielded by that unit will be forwarded to CSED staff at regional offices. In fiscal 2000 the customer service unit received 177,234 phone calls. If each phone call were completed in 5 minutes, it would require 7.1 full time equivalent staff (assuming no paid leave) to respond to the same number of phone calls. According to DPHHS information, the contract for the customer service unit supported 14 positions.

The reduction in staffing from 183 to 174 FTE is a 9.5 FTE reduction or division staffing at 95 percent of the FTE level funded by the 2001 legislature. The cumulative effect of staff downsizing and elimination of the customer service unit contract equates to a reduction in funding for 23.5 FTE. Vacancies or staff reductions necessary to achieve the budgeted level of vacancy savings are not included in the 23.5 FTE.

The reduction in FTE may:

- Result in a decrease in collections, which may result in fewer families receiving child support payments, families receiving less child support, and less revenue to the state for reimbursement of past welfare payments.
- Increased worker caseloads could decrease the division's ability to establish medical support orders assuring insurance coverage for children who would otherwise be covered by Medicaid,

which may increase Medicaid costs. CSED estimates that $2.7 million of Medicaid costs were avoided in fiscal 2001 and $1.4 million in the first half of fiscal 2002.

DISABILITY SERVICES DIVISION - USE OF GENERAL FUND AVAILABLE DUE TO REFINANCING

Disability Services Division (DSD) uses Medicaid funds for reimbursement of some services for developmentally disabled individuals that were previously funded with general fund. Costs that were previously charged 100 percent to the general fund are now being funded with general fund and federal funds at the Medicaid matching rate (about 27 percent general fund during the 2003 biennium). DSD estimates that refinancing efforts will "free up" about $1.2 million general fund in fiscal 2002 and $1.5 million in fiscal 2003.

According to DSD, the general fund available from refinancing efforts will be allocated in fiscal 2002: 1) $596,000 for a 2 percent rate increase to developmental disability program providers; 2) $40,000 for direct care worker increases that were not included in the DPHHS calculation during session; and 3) $450,000 to offset Medicaid short falls in the Health Policy and Services Division[3].

Legal Opinion Requested

LFD staff requested a legal opinion regarding whether the DSD plan for expenditure of the funds available due to refinancing efforts complies with appropriation statutes[4] and House Bill 2 given that: 1) DPHHS budget projections indicate that appropriations will be not be sufficient to cover projected expenditures in either year of the biennium;[5] and 2) provider rates in the Health Policy and Services Division and Addictive and Mental Disorders Division have been reduced to offset cost over runs.

House Bill 2 includes this language:

> "The developmental disability program is directed to use existing general fund appropriations within the developmental disabilities program budget to refinance services, if possible. General fund money made available through refinancing efforts may be used to: (1) reduce the developmental disability program waiting list; (2) improve wages paid by community providers to direct care workers; (3) provide a provider rate increase to community services providers; and (4) fund existing plans of care for individuals waiting for residential services.
>
> The developmental disabilities program will report to the legislative fiscal division semiannually in January and July: (1) the amount of general fund money that was made available through refinancing efforts; (2) the amount, scope, and nature of services provided by funds made available through refinancing; (3) the number of consumers, providers, and direct care worker staff benefiting from initiatives funded through refinancing efforts; and (4) the amount of additional state special and federal funds obtained through refinancing efforts."

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[3] Information on allocation of "freed-up" general fund provided by Gail Briese-Zimmer, Disability Services Division in personal phone conversation on March 6, 2002.

[4] 17-8-103 (1) MCA – unlawful for a department to expend in excess of legislative appropriations; 17-2-108 (1) expenditures shall be applied against any appropriated nongeneral fund money whenever possible before using general fund appropriations; 17-7-301(7)(b) If, in the second year of a biennium, mandated expenditures that are required by state or federal law will cause an agency to exceed appropriations or available funds, the agency shall reduce all nonmandated expenditures pursuant to the plan in order to reduce to the greatest extent possible the expenditures in excess of appropriations or funding.

[5] The February budget status report projects a $2.8 million general fund deficit in fiscal 2002. DPHHS projections estimate a short fall of $0.8 million ($2.4 million total funds) in CSED in fiscal 2003. These deficits remain after actions taken by DPHHS to reduce cost over runs.

"Items 5, 9, and 10 include appropriations of state special revenue for provider rate increases funded from the interest income on the tobacco settlement trust fund provided for in Article XII, section 4, of the Montana constitution. If the interest income on the tobacco settlement trust fund provided for in Article XII, section 4, of the Montana constitution is insufficient to fully fund the state special revenue appropriations in items 5, 9, and 10[6], the legislature intends that the department find alternative funding sources to fully fund the provider rate increases. Alternative sources may include but are not limited to enhanced Medicaid intergovernmental transfer programs and transfers of general fund money from other appropriations."

LFD staff has requested that legal counsel answer the following questions. Can DPHHS:

- Use the general fund made available through refinancing efforts in DSD for any purpose other than to mitigate the general fund deficit in other programs?
- Grant rate increases to providers in the Developmental Disabilities Program prior to fully funding the provider rate increases in Health Policy and Services and Addictive and Mental Disorders Divisions?
- Expand the scope of services or number of clients served in the Developmental Disabilities Program while service reductions are being implemented in other programs within DPHHS?

The response to these issues will be reviewed at the March 13 LFC meeting.

FAIM IIR REDUCTION

On January 16, 2001 DPHHS notified the Office of Budget and Program Planning that its estimates of cash assistance costs had increased to over $30 million for fiscal 2002 and $33 million for fiscal 2003, and that DPHHS believed a further reduction of $8.8 million in FAIM Phase IIR items was needed. The second reduction increases the total decrease in FAIM Phase IIR to $18 million of the $26 million in line item appropriations for FAIM Phase IIR. The funds have been (or will be) transferred to the cash assistance appropriation.

Cash Assistance Caseload

The executive rationale for funding reductions for FAIM Phase IIR has been related to increased cash assistance caseloads. The appropriation for cash assistance was $24 million for each year of the 2003 biennium. Fiscal 2001 cash assistance costs were $24.2 million and the caseload was 4,765 cases. Table 2 summarizes the cash assistance costs and caseload for fiscal 2000 through 2003.

[6] Items 5, 9 and 10 are the main appropriations for the Health Policy and Services Division, the Senior and Long-Term Care Division, and the Addictive and Mental Disorders Division, respectively.

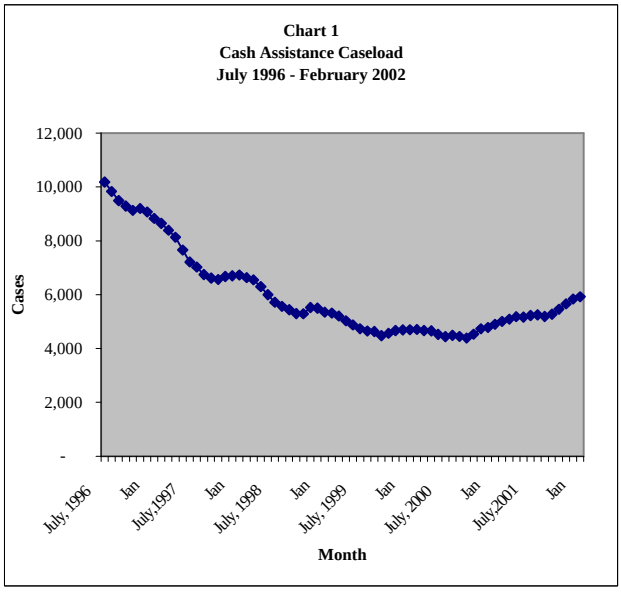
Using the current average annual cost per case of $5,316, the fiscal 2002 cost estimate of $30.2 million will support a caseload of 5,674 cases. The caseload that can be supported by the $33.2 million estimated fiscal 2003 cash assistance costs is estimated to be 6,057 if the costs per case increases 3 percent[7].

Table 2
Department of Public Health and Human Services
Summary of Cash Assistance Costs and Caseload

	Actual FY 2000	Actual FY 2001	Estimated FY 2002	Estimated* FY 2003
Cash Assistance Costs	$21,847,044	$24,236,328	$30,163,362	$33,166,903
Cash Assistance Cases (Monthly Ave.)	4,640	4,765	5,674	6,057
Percentage Increase		2.69%	19.08%	6.75%
Annual Average Costs Per Case	$ 4,708	$ 5,087	$ 5,316	$ 5,475
Percentage Increase		8.03%	4.51%	3.00%

Notes:
The costs per case increase is estimated to be equivalent to the increase in the Federal Poverty Index between 2002 and 2001 (approximately 3 percent).

The cash assistance caseload increased about 3 percent between fiscal 2000 and 2001. Based upon the caseload numbers derived by Legislative Fiscal Division (LFD) staff, the DPHHS estimated cash assistance costs would support a caseload increase of about 19 percent between fiscal 2001 and 2002 and almost 7 percent between fiscal 2002 and 2003.



The monthly caseload for July 1998 through February 2002 is illustrated in Chart 1. Caseloads have been gradually rising since the fall of 2000 and the historic decrease in caseload during the spring and summer did not occur in 2001. It is difficult to predict whether caseloads will continue to increase or whether caseloads will decrease during that spring and summer of 2002, which is more consistent with historical trends. Even if the caseload decreases during the spring and summer of 2002, it seems doubtful that it will decline to the level experienced in 2000, the base year for the 2003 biennium budget.

GENERAL FUND OFFSET

Other states have used an option in Medicaid - targeted case management - to help fund the cost of field staff working with foster care children. Targeted case management is a unique Medicaid service in that a state may define the target group to receive case management without providing the service to all eligible Medicaid recipients and without obtaining a waiver of federal Medicaid criteria.[8]

DPHHS already provides targeted case management to Medicaid recipients who are developmentally disabled and Medicaid eligible children who are seriously emotionally disturbed. DPHHS could also define foster care children as a target group and fund social worker contacts with such children at a

[7] The 2002 Federal Poverty Index update was published in the February 14, 2002 Federal Register. The index increased about 3 percent above the 2001 level.

[8] Under almost all other circumstances if a state were to limit receipt of benefits to a specific group, it would need to obtain a waiver of federal Medicaid criteria and document that the limitation was cost neutral to the federal government.

specified rate matched at the Medicaid service rate (about 73 percent during the 2003 biennium). Currently, some of these costs are funded fully from the general fund or 50 percent from federal funds.

The most significant implementation steps are:

- Amending the state Medicaid plan to include a new target group
- Defining the types of social worker activities that would qualify as a case management service
- Changing the time survey that allocates social worker costs to include case management services
- Determining a daily rate for a social worker case management service or contact
- Receiving federal approval of the amended cost allocation plan
- Defining protocols to eliminate billing for more than one case manager if a child is eligible in more than one target group[9]

The advantage in defining foster care children as a new targeted case management group is general fund savings in administrative costs in the child welfare program and centralized agency costs. It is difficult to estimate the general fund savings that could be achieved because of several unknown variables, such as the case management rate that could be supported and the number and type of social worker activities that would be defined as case management.[10] Additionally, DPHHS may be supporting some activities eligible for federal Medicaid funding from federal Title IV-E funds. Since administrative costs eligible for Title IV-E are matched 50 percent federal funds, the savings would be less than if costs offset by Medicaid funding were 100 percent general fund.

There are several disadvantages to implementing another targeted case management group. One is the increase in complexity of funding for the Child and Family Services Division, as well as centralized agency costs. A temporary disadvantage is the increase in workload to accomplish the change.

DPHHS has initiated steps to implement a community collaboration project as requested by the 2001 legislature. This plan would claim federal Title IV-E matching funds for eligible services and activities other agencies provide to Title IV-E eligible foster care children. Other agencies that typically provide services that are not currently reimbursed under the Title IV-E program include: the Department of Corrections; the Supreme Court; and schools. The recovery of federal matching funds would mean less general fund is needed to support existing services. The general fund no longer needed to support existing services could be used to provide other services and flexible funding to help maintain children in their communities and in their homes or it all or a portion of it could be used to offset current general fund costs. The Medicaid refinancing of social worker costs is not dependent on this plan and can be implemented much sooner since it doesn't require the cooperation of other agencies.

TOBACCO SETTLEMENT TRUST INCOME

The 2001 legislature appropriated $1.3 million over the biennium of interest income from the constitutional trust fund that receives 40 percent of the tobacco settlement revenue. The interest income funds part of the state share of Medicaid provider rate increases for most Medicaid providers, with the largest exception being DD providers. DPHHS has fully expended the tobacco trust interest income appropriations for fiscal

[9] For instance, a child may be both seriously emotionally disturbed and in foster care. Medicaid regulations specify that targeted case management may only be billed by one case manager. So a protocol would need to be established to determine whether Addictive and Mental Disorders, Child and Family Services or Disability Services Division would be the case management provider.

[10] The state of Michigan saved $2 to $3 million general fund implementing targeted case management for foster care children.

2002, granting provider rate increases on July 1, 2001. After legal review, it appears that DPHHS correctly expended the appropriations.

Projected costs continue to be above appropriation levels in fiscal 2003 and if DPHHS continues or increases provider rate reductions, there could be issues related to use of tobacco trust income in future biennia. Provisions of the constitutional amendment establishing the trust and governing expenditures from the trust do not allow trust principal or interest to be used for health related programs or expenditures in existence December 31, 1999. DPHHS can still legally use tobacco trust interest in fiscal 2003 even if some provider rates were to fall below levels in existence on December 31, 1999 by transferring all tobacco trust income appropriated for provider rate increases to the Senior and Long-Term Care Division and offsetting general fund appropriated provider rate increases for nursing home and community services in fiscal 2003.

In future biennia the legislature would need to evaluate use of tobacco trust fund income if Medicaid services are subjected to additional rate reductions.

FEDERAL CHIP GRANT

During the 2001 legislative session, the ongoing federal CHIP grant was assumed to continue at the federal fiscal 2001 amount of $15.2 million annually. However, the most recent grant for federal fiscal year 2002 has declined to $10.3 million, which is less than projected grant expenditures of $12.4 million in fiscal 2002. The federal fiscal 2002 grant reduction (colloquially known as the "CHIP dip) is consistent with federal authorization for CHIP. Future grant amounts are unknown, as is the potential for reallocation of any unspent grant amounts.

Montana has received five CHIP grants, which require a state match of about 19 percent during the 2003 biennium. Each annual grant must be spent within three years of receipt and after that time unexpended funds revert to the federal government. Montana has reverted a portion of the first three grants and was reallocated a portion from the first two reversions. DPHHS manages expenditures from the CHIP grant by using as much of the older grants as possible in order to minimize the reversions.

DPHHS and LFD staff concurred in an estimate of about $16 million in federal CHIP grant authority available above the amount needed to continue current level spending throughout the 2005 biennium.

OTHER INFORMATIONAL COMMENTS

Institutional Population

House Bill 2 includes this language:

> "Included in item 8b is general fund money of $1,400,277 in fiscal year 2002 and $1,400,224 in fiscal year 2003. This funding is one time only. The combined population of the two institutions (Eastmont Human Services Center and the Montana Developmental Center) may not exceed 88 individuals at the end of the 2003 biennium. If the disability services division has a population of more than 88 individuals at the two institutions at the end of the 2003 biennium, the division shall certify that a community residential setting was not available for the individuals remaining in the two institutions."

The DSD notified the Office of Budget and Program Planning and the LFD in January 2002 that the current combined population at Eastmont and MDC is 135. DPHHS plans to move 5 individuals out of MDC but indicated that plans for 2 new group homes serving 12 individuals may not be realized this biennium due to

the shift of funds from the DSD to the HPSD. The DSD projects that the combined population at the two institutions will remain around 130.

Operations and Technology Division

DPHHS has announced plans to create a new Fiscal Services Division. Accounting, purchasing and fiscal management functions will be moved to a new division. Budget and program planning, network communications and support, and external and internal systems programming and support will remain in the Operations and Technology Division. The department does not anticipate needing additional funding to complete this organizational change.

ISSUES AND OPTIONS

The following issues and options are not mutually exclusive. The LFC could chose to combine several of the options to form a more comprehensive response to the DPHHS budget status or it could choose to take several options that are independent of one another.

Issue 1: Ongoing General Fund Short Falls

The LFC could:

1) Direct staff to continue to monitor and report on DPHHS budget status.
2) Request that DPHHS indicate how it will respond to continued short falls.
3) Request that LFD and/or DPHHS staff thoroughly investigate the potential use of available federal CHIP authority to offset current general fund expenditures
4) Take no action.

Issue 2: DD Refinancing Revenue

The LFC could:

1) Request that DPHHS apply the entire $2.7 million general fund freed up from DD refinancing efforts to the general fund short fall.
2) Request that DPHHS apply portions of the $2.7 million general fund freed up from DD refinancing efforts to the general fund short fall, indicating which expenditures should continue.
3) Take no action.

Issue 3: Foster Care Children as a Targeted Case Management Group

The LFC could:

1) Request that LFD and DPHHS staff review the issue further and report back on potential cost savings and implementation at the next LFC meeting.
2) Request that DPHHS implement a new targeted case management group and report on cost changes.
3) Take no action.

APPENDIX A

DPHHS COST CHANGES – 2003 BIENNIUM

Table A-1 shows the biennial cost estimate of budget changes that have been made by DPHHS that have been of interest to the LFC. LFD staff prepared the biennial estimate by annualizing projected fiscal 2002 savings estimated by DPHHS for changes that would remain in effect through fiscal year 2003. LFD staff also adjusted the funding in fiscal 2003 for the change in the state match rate for Medicaid. A potential offset that is not included in the table is a possible general fund transfer from Medicaid nursing home and home based appropriations in fiscal 2003 if nursing home caseloads remain lower than projected during session. DPHHS staff indicated that such additional savings might occur.

The total changes made to date are about $53 million total funds, including $9.9 million general fund. The single largest item is appropriation allocations, which includes reallocation of federal TANF authority from FAIM IIR to cash assistance costs. Although this item is not part of the DPHHS plan to address the projected fiscal 2002 general fund short fall, it is included since the LFC has considered issues related to the TANF reallocation at two meetings.

PROVIDER RATE REDUCTIONS

Items 1 through 5 on Table A-1 list the types of providers that received a 2.6 percent rate reduction effective January 1, 2002. The initial reduction proposed for critical access hospitals has been withdrawn.

At this point in time, DPHHS is considering alternatives that may continue or increase rate reductions or withhold rate reductions in fiscal 2003 for Medicaid services such as hospital, physician, prescription drugs, and mental health services. Medicaid providers of nursing home, community based services for the elderly and disabled, and DD services received provider rate increases July 1, 2001 and those rate increases were not affected by the cost mitigation plan implemented by DPHHS, nor do these services appear to be included in considerations of potential rate reductions for fiscal 2003.

Most of the providers listed in Table A-1 initially received rate increases funded by the 2001 legislature, but in most instances rate increases approved by the legislature were lower than the subsequent 2.6 percent reduction.

Mental health services are unique. Several providers did not receive rate increases on July 1, 2001, nor were they subject to the 2.6 percent reduction. Those providers are: residential treatment centers, therapeutic family foster care, and therapeutic group homes.

Several mental health service providers received rate increases funded by the legislature and then received a 2.6 percent reduction. Mental health professional services are the single largest example.

Table A-1
2003 Biennium Total of Reductions, Limitations, and Appropriations Changes Made to DPHHS Budget

Action	Human & Community Svrs. Gen. Fd.	Human & Community Svrs. Total	Child Support Enforcmnt Gen. Fd.	Child Support Enforcmnt Total	Health Policy & Srvcs Gen. Fd.	Health Policy & Srvcs Total	Addictive & Mental Disrdrs Gen. Fd.	Addictive & Mental Disrdrs Total	Total Gen. Fd.	Total Total	Percent of Total
Provider Rate Reductions											
1 Hospital, Physician Rates	-	-	-	-	770,000	2,839,233	-	-			
2 Co-Surgeons and Ambulatory and Surgical Centers	-	-	-	-	136,722	505,572	-	-			
3 Critical Access Hospitals*	-	-	-	-	Withdrawn	-	-	-			
4 Out-of-State Hospitals	-	-	-	-	332,029	1,227,778	-	-			
5 Mental Health Professionals	-	-	-	-	-	-	63,391	233,743			
6 Drug Reimbursement - Mental Health Services Plan	-	-	-	-	-	-	132,600	132,600			
Subtotal Rate Reductions	-	-	-	-	1,238,751	4,572,582	195,991	366,343	1,434,742	4,938,925	9.4%
Service Limitations/Reductions											
7 Reduce Genetics Contract	-	-	-	-	24,000	24,000	-	-			
8 End Maximus Contract	-	-	-	668,843	-	-	-	-			
9 Reduce Staff	-	-	-	285,621	-	-	-	-			
10 Other Expenditure Reductions	-	-	-	157,409	-	-	-	-			
11 Reduce Intensive Case Management - Children in Therapeutic Group Homes	-	-	-	-	-	-	164,594	608,407			
12 Cap and Limit Room and Board for Therapeutic Group Homes***	-	-	-	-	-	-	480,000	909,971			
13 Prior Authorize Outpatient Therapy Above 24 Visits	-	-	-	-	-	-	448,894	1,659,291			
14 Reduce Care Coordination	-	-	-	-	-	-	119,705	442,479			
15 Restrict Out-of-State Residential Treatment	-	-	-	-	-	-	80,801	298,674			
Subtotal Service Reductions/Limitations	-	-	-	1,111,873	24,000	24,000	1,293,994	3,918,822	1,317,994	5,054,695	9.6%
Appropriation Reallocations											
16 FAIM IIR to Cash Assistance**	-	18,000,000	-	-	-	-	-	-			
17 Shift SEARCHS Costs to OTD	-	-	-	300,000	-	-	-	-			
Subtotal Appropriation Reallocations	-	18,000,000	-	300,000	-	-	-	-	-	18,300,000	34.7%
Transfers from Other Programs											
18 Nursing Home and Community Services	-	-	-	-	2,018,000	7,454,772	400,000	1,474,926			
19 Developmental Disabilities	-	-	-	-	450,000	1,659,292	-	-			
20 CHIP Administrative Savings	-	-	-	-	100,000	368,732	-	-			
21 Public Health Laboratories	-	-	-	-	74,000	208,366	-	-			
22 AMDD Programs	-	-	-	-	-	-	1,656,976	3,883,385			
Subtotal Transfers	-	-	-	-	2,642,000	9,691,162	2,056,976	5,358,311	4,698,976	15,049,473	28.5%
Other Changes											
23 Reduce Dept. Operating Costs	-	-	-	-	200,000	737,463	-	-			
24 Change from Co-pay to Co-Insurance	-	-	-	-	605,253	2,488,287	216,052	798,918			
25 Third Party Collections - Medicaid	-	-	-	-	985,457	3,641,328	-	-			
26 TANF MOE for Some Services*	-	-	-	-	-	-	Withdrawn	-			
27 Gate Keeping - Medical Necessity	-	-	-	-	-	-	247,104	913,395			
28 Eliminate Duplicate Services - School Based Srvs	-	-	-	-	-	-	224,226	829,647			
Subtotal Other Changes	-	-	-	-	1,790,710	6,867,078	687,382	2,541,960	2,478,091	9,409,038	17.8%
Total Change by Division	$ -	$ 18,000,000	$ -	$ 1,411,873	$ 5,695,461	$ 21,154,822	$ 4,234,343	$ 12,185,436	$ 9,929,804	$ 52,752,131	100.0%
Total Department Change	$ 9,929,804	$ 52,752,131									

Notes: *Items withdrawn since report was mailed to LFC.
** FAIM IIR appropriations are biennial appropriations. $18.0 million of the biennium appropriations were reallocated to the cash assistance appropriation.
'***New item since report was mailed to LFC on March 8.

Mental health community services providers for the following services did not receive rate increases July 1, but received the increases effective January 1: 20 percent for Community-based psycho-social rehabilitation and support; and 12 percent for adult foster care and adult group homes. Subsequently the increases were reduced by 2.6 percent.

Reduced provider participation is a risk of lowering reimbursement rates as noted by LFD staff at the December LFC meeting, and may increase if additional rate reductions are implemented. The single provider of in-home nursing services for children in a large area of western Montana notified DPHHS that it would no longer participate in the Medicaid program due to the 2.6 percent reduction. In order to maintain several children in their homes and move several children out of higher cost hospital and nursing home placements, DPHHS negotiated a rate increase for in-home nursing services for children equal to the rate paid in the home and community based services for seniors and disabled adults. By raising rates paid for in-home services for children, DPHHS was able to avoid cost increases and reduced the cost of care for several children.

SERVICE LIMITATIONS/REDUCTIONS

Service limitations or reductions account for 9.6 percent of the changes implemented by DPHHS. The smallest reduction is a decrease of $24,000 in the genetics contract administered by the Health Policy and Services Division. Changes to CSED were $1.1 million total funds and are discussed in greater detail in Appendix B.

Mental health service limitations in items 10 through 15 were discussed in the most detail at the December LFC meeting. LFD staff noted that some of the reductions, such as limitations in outpatient therapy and limiting room and board payments for Medicaid eligible children in therapeutic group homes, might result in cost shifts to other programs such as foster care and juvenile justice. The HJR 1 subcommittee of the LFC heard testimony from the administrator of the Child and Family Services about concerns over cost shifts at its February 7 meeting.

APPROPRIATION REALLOCATIONS

Appropriation reallocations of TANF funds from FAIM IIR to cash assistance costs were reviewed at the December LFC meeting. The shift of SEARCHS costs to OTD will offset some of the CSED funding short fall.

TRANSFERS FROM OTHER PROGRAMS

Transfers of general fund from other programs accounts for nearly one-third of the changes made by DPHHS. The largest transfer is from Medicaid appropriations for nursing home care and community based services, due largely to lower than anticipated nursing home caseloads. DPHHS recently indicated that transfer would also be available in fiscal 2003.

The transfer from developmental disabilities is due to reallocation of “freed up” general fund due to refinancing 100 percent general fund costs with federal Medicaid funds.
DPHHS expects a total of $2.7 million general fund to be freed up over the biennium. LFD staff requested a legal opinion about whether the additional amount above $0.45 million must be applied to the ongoing general fund short fall and rate reductions for other DPHHS providers.

Administrative savings in the CHIP program, reductions in the public health laboratory expenditures and savings in the Addictive and Mental Disorders Division offset about $2 million of the general fund short fall.

OTHER CHANGES

Other changes include some actions that DPHHS might have taken regardless of whether it was projecting a general fund short fall. For instance, item 25 includes a change in collecting funds from other payors to offset Medicaid costs and to correctly account for such payments.

Reductions in department operating costs include such actions as eliminating non essential travel.

Item 24 affects both Medicaid recipients and providers. DPHHS is shifting from a co-payment for services to co-insurance and an annual maximum payment of $200 per year to $500 annually. This change will require Medicaid recipients to pay more for services. Testimony received during appropriation subcommittee hearings in the last several legislative sessions indicates that co-payments and co-insurance can sometimes result in lower reimbursement to providers or discourage persons from seeking needed treatment. It is much easier to collect the co-payment if it is due at the time of sale, such as in the sale of a prescription drug. Other providers must sometimes provide the service before payment can be demanded, such as emergency care, and may not be able to collect all of the co-payment due. On the other hand, an advantage of higher co-payments may be that persons forego care that may be unnecessary to their recovery.

Items 26 through 28 impact mental health services. Item 26 – TANF MOE (maintenance of effort) for some services was withdrawn. Item 27 – gate keeping – medical necessity – requires changes to the documentation needed to admit or continue some persons in mental health services. Finally, item 28 eliminates payment for duplicate services provided in school based mental health services.

APPENDIX B

CHILD SUPPORT ENFORCEMENT

FISCAL 2003 REVENUE AND EXPENDITURE ESTIMATES

The state special revenue for the Child Support Enforcement Division is derived from two primary sources: federal incentive funds and the state share of collections for TANF cases. Legislative staff is concerned the estimated federal incentive revenue may be overstated by $400,000 and the estimated state share of TANF collections may be overstated by $200,000. Legislative staff is also concerned that the department's estimated expenditure of state special revenue may be understated by $300,000. Because each dollar of state special revenue or general fund draws down $2 of federal matching funds, the effect on the program is triple the differences in the estimates. Differences of $900,000 in state special revenue actually equate to $2.7 million total funds. There are two primary reasons for the potential difference: 1) state share of TANF collections; and 2) federal incentive funds.

State Share of TANF Collections

The department estimates that welfare cases are increasing about 100 per month, which will result in an additional 1200 – 1800 welfare cases in the Child Support Enforcement Division. The department estimates that collections will equal the average support order in Montana (about $200) for each of these cases resulting in additional revenue of $250,000. Legislative staff have concerns with this calculation. First, calculations based upon information contained in Montana's federal fiscal 2000 report indicates an average of $38 per month is collection on current TANF cases (rather than the $200 per month contained in the average support order). Second, it is legislative staff understanding that the state only keeps a portion of these collections (about 27%). The department's estimate does not appear to consider this. For example, if the $200 average support order is collected the state retains only $54. If the average collection per TANF case is $38 the state retains only $10.

Based upon the department's estimate of cash assistance costs and the current average costs per case, legislative staff projects that the estimated cash assistance costs will support a caseload of 5,674 in fiscal 2002 and 6,057 in fiscal 2003, an increase of 383 cases. If half of these cases include 1 child and half these case contain 2 children that do not have the same noncustodial parent, the CSED would probably increase by about 575 cases. Legislative staff estimates the potential increase in child support state special revenue due to an increase in the TANF caseload is about $70,000 ($180,000 less that the department's estimate).

Federal Incentive Funds

The department estimates that Montana's share of the federal incentive funds will remain at a constant percentage and that the actual dollars Montana will receive increase ($400,000 between fiscal 2002 and 2003) because the total pool of funding available at the federal level increases. The department's estimate assumes that:

- Montana's performance as measured by the federal indicators will continue at the federal fiscal 2000 level
- Other states do not improve their performance. Improved performance by other states coupled with consistent or worse performance by Montana would decrease the percentage of

the pool that Montana is eligible to receive. Depending upon the size of decrease in Montana's percentage share the actual dollars received could change.

Improved performance by other states seems likely given that the September 28, 2001 letter from the federal Department of Health and Human Services states "In summary, 29 states did not receive one or more of the five incentive payments, because they failed to meet the 90% data reliability standard, or the performance standard, or both." This leads the reader to conclude that it is possible that 29 states could increase their performance and receive an increased share of the federal incentive payments available.

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